Remarks

Claims 1 - 18 are pending in the application.

Claims 1-4 and 9-18 stand rejected under 35 U.S.C. §102(e) as being completely anticipated by the Provost et al. U.S. Patent No. 6,341,265.

Claims 5-8 are rejected under 35 U.S.C. §103(a) as being unpatentable over the Provost et al. reference in view of the Doyle Jr. et al. U.S. Patent No. 4,916,611.

Applicant has carefully considered the arguments advanced by the Examiner in rejecting the claims of this application and respectfully requests favorable reconsideration in view of the following comments.

Applicant's Invention

Applicant's invention as disclosed and claimed provides a rules-based system (RBS) independent of any database resident at the insurance companies system or third party processor of Employer sponsor health plans.

Applicant's RBS is a highly complex, specialized, and sophisticated artificially based system. The RBS is a web enabled adjudication system that emulates every insurer's comprehensive adjudication logic, while maintain the insurer's clinical polices, benefit plan provisions, reimbursement rules, proprietary coding logic, utilization guidelines, etc. Additionally, applicant's RBS system will process health insurance industry for all classes of benefits, including commercial insurance products issued by Aetna, Cigna, and the like, and Employer sponsored health benefits, and government health plans such as Medicare and Medicaid.

One of the features of Applicant's invention is the RBS builds health insurance industry databases that impact health care constituents by reverse engineering the adjudication process and mapping these technical and system related algorithms to the RBS system to generate and make transparent health insurance data. One main purpose of the invention is to automate health insurance industry data via the web enabled technologies, making the health insurance data readily available, for instance with the

intent of making the insurance industry's adjudication process transparent to all health constituents.

By default the information distributed by the insurance company, i.e. their EOB (Explanation of Benefits), includes but is not limited to patient eligibility and status. By default the pre-adjudication process includes patient eligibility and status from the insurer's data base.

Applicant's invention as disclosed and claimed relies on the insurance company's clinical policy and health industry clinical information. As set forth in independent claim 1, Applicant's RBS includes:

reviewing frequency and limitations relevant to codes and clinical polices as defined by the insurer's health insurance plan while emulating the insurer's adjudication process to report the insurer treatments and conditions standards of care with clinical indicators;

defining insurer treatments and conditions and adopting utilization guidelines and clinical protocols, including coding relationships;

analyzing the insurance claim and adjudicating the insurance claim then issuing a preliminary EOB as the insurer would, thus verifying compliance of treatment and conditions based on the insurer's adjudication and insurance industry standards (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, views of physicians practicing in the relevant clinical areas, and other relevant factors) to determine monetary allowances for medical services; and

after issuing the preliminary EOB, the RBS assumes clearinghouse functionality and forwards claims to the appropriate insurance company.

Claim Rejections 35 U.S.C. § 102 (e)

Claims 1-4 and 9-18 stand rejected under 35 U.S.C. §102(e) as being completely anticipated by the Provost et al. U.S. Patent No. 6,341,265. The Examiner argues Provost

teaches all the structural limitations of the claimed invention as the basis for the rejection. The prior art cannot anticipate the claim if there is any structural difference. It is well settled that a single prior art reference anticipates a patent claim if it expressly or inherently describes each and every limitation as set forth in the patent claim. Inherent anticipation requires that the missing descriptive material is "necessarily present," not merely, probably or possibly present, in the prior art.

Applicant respectfully disagrees with the rejection of the claims as being anticipated by Provost for at least the following cogent reasons.

Provost relates to a method and system for creating a claim from the displayable claim diagnosis codes and treatment codes are entered, it is therefore a claim creation system (col. 6, lines 2-6). The medical technician is permitted to enter multiple diagnosis codes describing the diagnosis of the patient and one or more treatment codes (col. 3,line 66 to col. 4, line 4). The medical technician can amend the treatment code or any other desired information on the insurance claim to place the claim in condition for payment (col. 6, lines 12-21).

It is well known to those skilled in the art of building health insurance products, defining clinical policies, developing coding edits, evaluation reimbursements and charges, risk management, building alternative funding models, that Provost is a claim capturing or claims scrubbing system that is restricted to treatment codes and diagnosis and that these codes have predefined definitions and coding conventions in the public domain. For example:

Diagnosis codes are issued and defined by the Center of Disease – Federal Government; The diagnostic codes are defined, and include coding guidelines and conventions within the International Classification of Disease version 9 (commonly referred to as ICD-9 codes).

Treatment codes are defined by the American Medical Association (AMA). The treatment codes, documentation guidelines, and coding edits are defined in the AMA's CPT (common procedural terminology) database.

ICD-9 diagnostic codes and CPT codes have been part of the public domain for over 30 years. Federally mandated regulations recognize ICD-9 and CPT codes to be part of the HIPAA regulations. ICD-9 and CPT codes are the data set standards for the health insurance industry.

Provost relies exclusively on these diagnosis codes and treatment codes to determine if the claim is in a condition to be paid (col.3 lines 24-30; col. 5, line 66 to col. 6, line 6, 12-21; col. 6, lines 2-11 and col.9, lines 53-58).

The central processing system in Provost does not emulate the insurer's adjudication process, and does not issue preliminarily the insurer's EOB. The central processing system is a claim capturing system that verifies that the physician, patient, and insurer are included in the claim form (col. 2, lines 3-10).

The central processing system converts the medical insurance claim into the appropriate format. Upon adjudication and approval of the insurance claims by the insurer, the insurer issues a check. When the insurer issues a check it attaches an (EOB) explanation of benefit.

Validating the treatment codes and diagnosis codes essentially translates into knowing if the codes reported on the claim are outdated, consistent with predefined coding conventions that are part of the public domain. By correcting an invalid code the claim is more accurate, and eligible to be paid. However, when the claim is submitted to the insurance company the insurance company adjudicates the claim based on its adjudication intelligence, and business rules, including clinical polices.

For example, Aetna's clinical policy defines chronic pain as having pain for three consecutive months the ICD-9 code-diagnosis code- 338.21 is used to report the term "chronic pain". Reporting ICD-9 code on the claim less then 338.21 would be denied because the treatments rendered were premature since the treatments were rendered prior

to three months, as required by Aetna. The ICD-9 338.21 may be correct, however, not payable. In contrast to Applicant's invention as disclosed and claimed, Provost would have indicated the claim was in condition for payment when in fact it would not be paid.(col. 6, lines 12-21).

In a further example, Aetna and Cigna consider treatment code 76085 to be experimental and investigation and the determination is based on evidence based medicine. The American Medical Association refers to CPT code – treatment code-76085 to be an add-on procedure to mammography tests. These definitions are very different. Aetna and Cigna's adjudication process would have denied the service because they deemed it not medically necessary while the AMA CPT database renders a definition of the code. In contrast to Applicant's invention as disclosed and claimed, Provost would have indicated the claim was in condition for payment when in fact it would not be paid (col. 6, lines 12-21).

In contrast to Provost, Applicant's RBS system as disclosed and claimed adjudicates the claim after it has been submitted by a claim system and processed in accordance with the insurer's adjudication process.

The adjudication process in Applicant's invention as disclosed and claimed goes beyond processing treatment codes AMA CPT codes or the governments ICD-9 disease classification but rather incorporates the necessary audit and fraud and abuse triggers issued by the insurer and further includes, but it is not limited to other resources within the health insurance industry.

Provost's method and system for interactively creating and submitting insurance claims and determining whether the submitted claims are in a condition for payment by an insurer does not include the insurer's adjudication process or considerations of insurer specific or health insurance health data. Upon adjudication and approval of the insurance claims by the insurer the insurer issues a check. When the insurer issues a check the insurer attaches an (EOB) explanation of benefit.

In contrast to Applicant's invention as disclosed and claimed, Provost is unable to emulate the insurer's adjudication process, and does not teach, disclose or suggest emulating the insurer's adjudication process. Accordingly, Provost is deficient with respect to this element of Claim 1, 16 and 18.

Also, in contrast to Applicant's invention as disclosed and claimed, Provost is unable to issue a preliminary (EOB) explanation of benefit, and does not teach, disclose or suggest issuing a preliminary EOB. Accordingly, Provost is deficient with respect to this element of claim 1, 16 and 18.

Additionally, in contrast to Applicant's invention as disclosed and claimed, Provost does not process insurer data that is reflected in the insurer's EOB, and does not teach, disclose or suggest processing insurer data that is reflected in the insurer's EOB. Accordingly, Provost is deficient with respect to this element of claim 1, 16 and 18.

Further, in contrast to Applicant's invention as disclosed and claimed, Provost does not submit a pre-adjudicated claim to a designated payer in accordance with the patient benefit plan because it does not include the insurer's adjudication process. Provost does not teach, disclose or suggest submitting a pre-adjudicated claim to a designated payer in accordance with the patent benefit plan because it does not include the insurer's adjudication process. Accordingly, Provost is deficient with respect to this element of claim 1, 16 and 18.

Accordingly, Applicant's submit that claims 1-4, 9-18 are not anticipated by Provost et al. U.S. Patent No. 6,341,265 and requests allowance of these claims for at least the above reasoning.

Claims 2-4, 9-15 and 17 are dependent directly or indirectly on independent claims 1and 16 and it is submitted that these claims are likewise distinguishable over Provost for similar reasoning and for further limitations clearly set forth therein and not found in the independent claims and likewise requests allowance of these claims.

Claim Rejections 35 U.S.C. §103 (a)

Claims 5-8 stand rejected under 35 U.S.C. §103(a) as being unpatentable over the Provost et al. reference in view of the Doyle Jr. et al. U.S. Patent No. 4,916,611.

Applicant submits that combining the teachings of Doyle with Provost, if such a combination can in fact be made, does not overcome the deficiencies of Provost as set forth above and according, Doyle is also deficient with respect to at least the claim elements set forth above in the discussion of Provost.

For example, in both Doyle and Provost, the health care provided information is limited to treatment and diagnosis codes, and the information is restricted to payable medical services, not benefit plan provisions or insurer clinical policies or medical necessity definitions. Accordingly, Doyle is also unable to emulate the insurer's adjudication process as disclosed and claimed in Applicant's invention.

Applicant submits that claims 5-8 contain allowable subject matter for similar reasoning as set forth in connection with claims 1-4 from which they depend and for additional limitation clearly set forth therein.

Conclusion

Applicant submits that all the claims of the application are now in condition for allowance and earnestly solicits such action at an early date. The Examiner is invited to call Applicant's attorney if any questions remain following review of this response.

Respectfully submitted,

Dated: September 5, 2006

By: Jack M. Pasquale

Jack M. Pasquale
Attorney for Applicant
Registration No. 31,052

WARE, FRESSOLA, VAN DER SLUYS
& ADOLPHSON LLP
Bradford Green, Building Five
755 Main Street, P.O. Box 224
Monroe, Connecticut 06468
Telephone: (203) 261-1234
Facsimile: (203) 261-5676